Exhibit A

Description of Accidental Disability Plan and the Unique AMEX Benefits

I. The Accidental Disability Plan includes 3 separate programs. The Master Policies and service contract included in the Accidental Disability Plan are as follows:

(1) Master Policy GA00N002000897 issued by RELIANCE ;

(2) Master Policy BH-103 issued by FIDELITY; and

(3) On Call International Service Agreement issued by OCI;

Such Master Policies and service agreement are attached hereto as Exhibit B. A Schedule to the RELIANCE Master Policy for the purposes of the Plan will be issued after execution hereof and will be attached hereto. Such Master Policies, Schedule, and service contract shall together serve as the description of the Accidental Disability Plan.

II. The Master Policy and Schedule from RELIANCE includes the Unique AMEX Benefits, which are:

A. Exclusive benefit levels:

1. HEALTHEXTRAS will exclusively offer the $1.5 million lump-sum single coverage, and $1.5 million lump-sum dual coverage, levels through the AMEX Plan.

2. HEALTHEXTRAS will exclusively offer the $2.3 million-dollar annuity option. This annuity will be structured with $500,000 initial payment and a $7,500 (seven thousand and five hundred dollars) monthly payment for twenty (20) years.

B. Exclusive pricing:

1. AMEX will have the right to offer the $1.5 million lump-sum coverage benefit at the same price or below the price that HEALTHEXTRAS charges for $1 million lump-sum coverage through any other entity. These prices are currently $9.95/month for $1 million lump-sum single coverage and $14.95/month for $1 million lump-sum dual coverage. Such exclusive pricing will also provide at least the same coverage terms and conditions as are applicable to similar programs accessible through any other entity.

2. AMEX will have the right to offer the $3 million single coverage at the same price or below the price HEALTHEXTRAS offers for $2M single coverage with any other entity. This price is currently $14.95/mo. Such exclusive pricing will also provide at least the same coverage terms and conditions as are applicable to similar programs accessible through any other entity.

C. Exclusive Promotions:

1. HEATHEXTRAS agrees to promote any $1.5 million dollar benefit level exclusively to AMEX' Cardmember and/or Customer base.

2. HEALTHEXTRAS agrees to promote any $2.3 million dollar benefit level exclusively to AMEX' Cardmember and/or Customer base.

III. HEALTHEXTRAS acknowledges that, upon execution hereof, it will discontinue any marketing relating to the above benefit level(s), as previously offered by HEALTHEXTRAS with other third parties.

Exhibit B

Description of Services and Coverage

[attach Description of Coverage or Service Terms & Conditions here]

RELIANCE NATIONAL INSURANCE COMPANY

(Herein called the "Company")
77 Water Street, New York, New York 10005

GROUP ACCIDENT AND SPECIFIED EXCESS LOSS CERTIFICATE

This Certificate furnished by Reliance National Insurance Company (called "we", "ou in this Summary) describes the coverage that will be provided for all those persons called Persons as defined in this Certificate. Coverage will be provided for the losses describe subject to the terms of the Master Policy. This Certificate is issued to the Participating I Institution named in the Schedule.

This Certificate is not a contract of insurance. The complete terms and conditions each Insured Person's coverage are in the Master Policy issued to the Policyholder nam Schedule. The Master Policy may be changed or terminated without the consent of or each Covered Person.

CONSIDERATION - TERM

Coverage under the policy is provided in consideration of the premium paid by the Par Financial Institution. The premium due is shown in the Schedule. The term of co such Participating Financial Institution will begin on the Effective Date and en Expiration Date as shown in the Schedule. All periods of insurance will begin and en AM Standard Time at the address of the Participating Financial Institution.

RENEWAL

Coverage may be renewed by us for further consecutive terms by the payment of our rate in effect at the time of renewal.

If coverage is not renewed, insurance will terminate on the date to which premiums paid, subject to the Grace Period provision.

President

Secretary

Dennis Busti

Jeffrey A. Welikson

GA 00 N002 00 0897

TERMINATION OF THE POLICY

The Policyholder may terminate the Policy at any time on or after the first anniversar Date by sending us written notice. The Policy will be terminated on the date that Policyholder's written notice, or later if the Policyholder so specifies. We will ren unearned premiums that were paid. We may terminate the Policy on any Policy Anni sending the Policyholder at least 31 days' advance written notice. The Policy will als any scheduled or renewal premiums are not paid by the end of the 31 day Grace Period

Termination of the Policy will not affect a claim for a loss which occurs while the Polic

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

A Covered Person's coverage will take effect on the later of: (1) the Effective Da Schedule; or 2) the date he or she becomes a Covered Person as defined in the Policy.

A Covered Person's coverage will end on the earliest of: (1) the date the Policy termin he or she is no longer a Covered Person as defined in the; or (3) the date the Partici Institution's coverage ends.

Termination of coverage will not affect any loss resulting prior to the date of terminati

POLICY PREMIUM

The premium for the Policy is shown in the Schedule.

Premium Due Dates: The premium for the Policy is payable [monthly, quarterly, se annually] in arrears, that is, on the first day of the [month, quarter, half-year, or year] Policy Premium is due in advance of the date it becomes calculated. The Policy will ter day of the period for which premium is paid, subject to the 31 day Grace Period.

Grace Period: A Grace Period of 31 (thirty-one) days from the Premium Due Date is for the payment of each premium due after the first premium payment. If any prem before the end of the Grace Period, this insurance will automatically terminate at the for which premiums have been paid. During the Grace Period, the policy will stay in f

Payment of Premium: The Policy Premium shall be paid to us by the Partici Institution. Policy Premiums may also be paid to us by any other person accordi agreement among the other person, the Participating Financial Institution and us.

Change of Premium: After a Participating Financial Institution's coverage under the P force for 12 months, we have the right on the Policy Anniversary date to change the rat premiums will be calculated. We will give the Participating Financial Institution notice the Policy Premium at least 30 days before the Premium Due Date on which it is to be

DEFINITIONS

In this Policy:

Accident - means bodily Injury directly or independently caused by specific accident with another body or object which is: (a) unrelated to any pathological, functional, or disorder or Injury; and (b) causes loss while the Covered Person is covered under this P

Covered Person- means an officially designated cardholder of a Participating Institution who is over the age of 18, but under the age of 65.

Deductible Amount - means the amount that must be paid for medical expenses by the Person and/or the Covered Person's Qualifying Health Coverage before benefits ar under this Policy. The Deductible Amount is listed in the Schedule of Benefits.

Family - means any Covered Person's lawful spouse and/or unmarried children under 19 (25 years old if enrolled as a full-time student in an accredited college, university, or technical school) who reside and are chiefly dependent on the Covered Person for su

Injury - means a bodily injury caused by an Accident which is the sole cause of Loss.

Physician - means any duly licensed medical practitioner: (1) who is acting within the her license; and (2) who is not the Covered Person or Family member.

Qualifying Health Coverage -- means any (a) blanket or general policy of medical, hospital insurance, (b) policy of accident or sickness insurance, (c) nongroup medical or hospital insurance, (d) nongroup or group hospital or medical plan issued by a hospital or medical service corporation, (e) nongroup health maintenance contract iss Health Maintenance Organization, (f) self-funded or self-insured employer group he (g) health coverage provided to persons serving in the armed forces of the United Stat Medicare or Medicaid which was in effect within 30 days prior to the Covered Person date of coverage.

SCHEDULE A - PERMANENT TOTAL DISABILITY

If a Covered Person provides Us with written proof that a Total Disability: (a) resulted f
Injury caused by an Accident while the Policy is in effect; (b) commences within 365 da
the date of the Accident causing such Injury; (c) continued without interruption, for at l
year; and (d) results in the entire and irrecoverable loss of :

the use of both hands or both feet; or
the use of one hand and one foot; or
the sight of both eyes; or
the hearing of both ears; or
the ability to speak;

We will pay the Principal Sum as shown in the schedule.

Total Disability means the Covered Person's inability to perform the material and subst
duties of any occupation or attend to any business of any and every kind for which the C
Person is or can be reasonably fitted by education, training, or experience.

The maximum amount for this benefit under the Policy is $1,000,000.00.

Eligibility Requirements

In order to be eligible for this benefit, the Covered Person must provide written proof of underlying Qualifying Health Coverage, which specifies coverage for an organ transplant procedure. Prior to payment of this benefit, the Covered Person must also provide two opinions that support, as Medically Necessary, the organ transplant procedure. The written opinions must be from board certified specialists in the involved field of surgery. In addition such written notice, the Covered Person must provide written proof of payment by them of their Qualifying Health Coverage for medical expenses incurred as a result of an Human Transplant procedure.

The Covered Person must undergo the Transplant procedure while covered under this P the expenses incurred toward the satisfaction of the deductible must be incurred while th coverage is in effect.

Benefit Description

Upon meeting the Eligibility Requirements delineated above, We will pay the cost of a H Organ Transplant procedure, not to exceed $250,000.00, once:

a) the Covered Person's Qualifying Health Coverage for such a benefit is exhausted

(b) upon meeting the initial Deductible Amount as shown in the schedule, whichever greater.

Human Organ Transplants. This benefit may be applied only for services related to the transplant of one of the following human organs:

Heart;
Heart/Lung;
Liver;
Pancreas;
Lung; or
Kidney.

The transplant of any of these organs must be a "Covered Procedure" as defined under the Covered Person's Qualifying Health Coverage.

This benefit amount may only be applied to services and supplies that are considered Medically Necessary and related to the transplant procedure as described under the Covered Person's Qualifying Health Coverage. Benefits will be based on the Qualifying Health Coverage that provides coverage for the Covered Person or Dependent.

Medically Necessary means services will be based upon medical criteria supported and by national and community standards. Medically Necessary services or supplies mu rendered in a treatment plan setting consistent with the symptom and/or diagnosis of the Person or Dependents; and (2) be appropriate with regard to national or community st good medical practices (a) in accordance with generally accepted current professiona practice; and (b) based on generally accepted scientific evidence by the majority o professional medical practice.

A treatment, service, supply, or medicine will not be considered Medically Necessary if of a treatment plan that is considered to be experimental or for research purposes.

Covered Transplant Procedures may include such services as the following: (1 procurement. This consists of removing, preserving, and transporting the donated hospital room and board and medical supplies; and (3) diagnosis, treatment and surg Physician.

The following may not be considered Covered Transplant Procedures: (1) services not o by a Physician; and (2) services for which the Covered Person or Dependent would not have to pay if there were no insurance.

D. In Conjunction herewith, Client further agrees that:

(a) OCI is authorized to represent Client, in Client's name, to recover the value of any benefits paid or services provided as aforesaid:

(b) OCI is authorized to, its own discretion, initiate, compromise, settle, discount and end legal proceedings on Client's behalf and in Client's name to recover the value of said benefits/services; and, to sign and endorse any documents, drafts, releases and/or pleadings ass deemed necessary for this purpose with the same force and effect as though Client's authorization appears thereon:

(c) Client shall endeavor to secure the cooperation of its Customers in this regard as deemed necessary by OCI, including: (1) acquiring the authorization to file suit in Customer's name; (2)securing the cooperation of customers to sign and timely deliver any such documentation or legal process ac is reasonable necessary to represent and protect Client's subrogation/recovery rights; and (3) to secure and present such testimony from its Customers as may be necessary of this purpose; (4) to promptly provide any Authorizations or Releases as may be deemed necessary by OCI.

4. This agreement shall be governed and construed according to the laws of New Jersey and the United States applicable therein.

In Witness Whereof, this Agreement has been executed by the duly authorized officers of each of the parties hereto.

Health Extra, Inc.

David Blair
Chief Financial Officer
2275 Research
Rockville, MD 20850

On Call International

Michael J. Kelly
President
Eight C Industrial Way
Salem, NH 03079

ON CALL INTERNATIONAL

Schedule A

Health Extra , Inc.
Health Extras
Estimated number of Cardholders: 30,000
Minimum number of Cardholders: 10,000 for services. 30,000 for Evacuation/Repatriation Coverage
Plan description attached:
Dedicated Toll Free Number: yes

Medical Assistance Services
World Wide Medical Information
Referral to Physicians, Hospitals and other Health Care Facilities
Medical Monitoring
Prescription Replacement
Verification of Coverage
Evacuation/Repatriation
Return of Deceased Remains

Travel Assistance
Translation Assistance
Emergency Travel Arrangements
Embassy and Consular Assistance
World Wide Legal Assistance
Lost Document Assistance
Return of Minor Children
Return of Automobile
Credit Card Replacement Assistance

Concierge Assistance
Restaurant/Hotel Reservations
Entertainment/Sporting Events
Shopping Locations

ON CALL INTERNATIONAL

Schedule A cont.

Health Assessment/ Information
Nurse On Call

Insurance Coverage

Evacuation Repatriation Coverage-Up to $50,000 combined single limit per card
Return of Minor Children -Up to $1,000 coverage limit per card
Return of Traveling Companion -Up to $1000 coverage limit per card
Transportation to Join Disabled Patient- Up to $1000 coverage limit per card
Repatriation of Mortal Remains-Up to $4000 coverage limit per card

Family is defined as: Father, mother, children and step-children

ON CALL
INTERNATIONAL

EXHIBIT C
Underwriting, Marketing, and Customer Service Terms

I. UNDERWRITING

A. After this Agreement has been in effect for more than twelve (12) months, AMEX reserves the right to change the underwriter of the accidental disability portion, or other portions, of the Accidental Disability Plan, including but not limited to having any portion of the program underwritten or provided directly by AMEX or one of its affiliated entities, or by arranging for the program to be underwritten or provided by a third party.

B. In the event AMEX chooses a third party to underwrite or provide any portion of the Plan, AMEX will consult with HEALTHEXTRAS in advance, and will reach mutual agreement with HEALTHEXTRAS prior to implementing such change. AMEX agrees to give HEALTHEXTRAS at least twelve (12) months written notice in the event AMEX wants to change the underwriter of the accidental disability portion of the Plan from RELIANCE to another underwriter, provided such change is effective on or before April 30, 2002. For such a change in underwriter that is effective after April 30, 2002, only sixty (60) days prior written notice is required.

C. Should such a change in underwriter occur, HEALTHEXTRAS will continue to handle the marketing, enrollments, and customer service for the Accidental Disability Plan and further agrees to provide payments for the new accidental disability portion underwriter in the same amount as is paid to RELIANCE. In particular, the new underwriter of the accidental disability portion will receive from HEALTHEXTRAS disability insurance fees of $27 per $1 million lump-sum coverage per enrollee or the current rate.

D. HEALTHEXTRAS will also pay AMEX "Marketing Fee" at 5% of revenue net refunds beginning the later of the date the Underwriting risk is transferred or April, 2002, which ever is first. HEALTHEXTRAS' payments to the underwriter(s) may be made directly to the underwriter, or may be made through AMEX to the underwriter, as determined by AMEX.

E. HEALTHEXTRAS will provide Accidental Disability insurance and non-underwriting program benefits and Travel Medical Care insurance and non-underwriting program benefits at the coverage levels stated in the contract through at least an "A" rated insurer or above. If RELIANCE no longer provides this insurance or if RELIANCE's Best rating drops below "A," HEALTHEXTRAS will provide an alternate "A" rated insurance underwriter. If AMEX changes the underwriter in accordance with I(A) above, AMEX will provide an alternate insurance underwriter with at least a Best rating of "A" or above.

F. HEALTHEXTRAS warrants and represents that all claims will be covered in full provided that the claimant presents letters from two board certified physicians that confirm the claimant is permanently and totally disabled as defined in the Master Policy. The underwriter and/or HEALTHEXTRAS will be required to (1) notify AMEX in advance of denying any claim; and (2) allow AMEX to review the claim before communicating with the enrollee/policyholder. In the event that a claim that is due to be denied appears to be "borderline", or presents a potential for negative public relations in the press, media, or through customer service channels,

HEALTHEXTRAS agrees (i) to pursue the underwriter as an advocate for the claimant in an effort to obtain coverage for the claim; and (ii) to assist AMEX in mitigating any public relations response as a result of the claim denial.

II. MARKETING

AMEX has the final controlling right on all-marketing and other promotional materials and scripts including solicitations, fulfillment, customer service, and retention materials. AMEX reserves the right to commence marketing of the program in lieu of HEALTHEXTRAS' marketing efforts. Once AMEX begins marketing the Plan itself, HEALTHEXTRAS will pay to AMEX a $40 marketing fee per enrollee. If AMEX elects to change the Underwriter, AMEX shall provide HEALTHEXTRAS with copies of State policy filings and necessary Department of Insurance approvals.

III. CUSTOMERS

A. A Customer is an enrollee when they accept the terms of a solicitation to an AMEX branded insurance program and/or an AMEX branded non-insurance service (the "Enrollee").

B. The closing of an Enrollee's AMEX Card account includes, but is not limited to:

(1) The Enrollee has died;
(2) The Enrollee has requested to terminate their relationship with the Card franchise;
(3) The Enrollee's Card Account is cancelled by AMEX for any reason.

A. If the Enrollee's AMEX Card account closes (1) the Enrollee will be offered the opportunity to migrate the Plan fee payment to another American Express Card account; and (2) should all AMEX Card accounts be closed then the Enrollee, will be offered the opportunity to migrate the Plan fee payment to another issuers credit or charge card, and (3) AMEX will continue to receive all fees associated with that Enrollee.

Exhibit D

Quality Standards

1. Quality Assurance/Accuracy Expectations as set forth in the chart at the end of this section.

2. HEALTHEXTRAS must strive for 100% accuracy for 100% of calls and submissions handled. Quality/accuracy standards defined below will be aggregated through weighted measurement to determine overall aggregate quality/accuracy performance levels attained during each quarter.

3. To ensure the continuous attainment of quality and service delivery standards described, HEALTHEXTRAS agrees to do the following:

   (a) Designate a quality assurance individual to measure regularly (daily, weekly, monthly, annually) and report directly to AMEX service delivery and quality results against standards in accordance with the requirements in this Exhibit and any reporting requested by AMEX and mutually agreed upon at a later date.

   (b) Assist AMEX in conducting customer satisfaction research via surveys and other forms of customer monitoring such as Customer Response Cards (CRC) and Service performance Monitoring (SPM). HEALTHEXTRAS must strive for 100% of CRC and SPM responses to achieve "extremely or very satisfied" with 95% minimal acceptable.

   (c) Dedicate to and maintain a controlled, continuous improvement process to develop and implement improved service delivery recommendations and solutions to problems.

1. Timeliness Expectations

HEALTHEXTRAS must strive for 100% timely handling of all calls, Enrollee submissions received and service requests.

2. Service Expectations

HEALTHEXTRAS must train and have available sufficient staff to provide adequate customer service to Enrollees and enrolling customers.

3. Mystery Shopping

AMEX reserves the right to monitor HEALTHEXTRAS compliance with these Quality and Timeliness Standards by assigning up to ten (10) designees in any one year period to enroll in the Service without indication to HEALTHEXTRAS that they are AMEX designees. The enrollment fees associated with such "mystery shoppers" shall be reimbursed to AMEX by HEALTHEXTRAS upon AMEX's written request. AMEX shall not be obligated to disclose the names of such "mystery shoppers" to HEALTHEXTRAS at any time, although AMEX can, at its discretion, advise HEALTHEXTRAS of any remarks or feedback received from the "mystery shoppers."

4. Customer Services and Fulfillment.

(a) (HEALTHEXTRAS will establish and manage an Enrollee services phone center. This center will be operational 24 hours a day, 7 days a week. Enrollees will be able to contact the center via a toll-free number used exclusively for the Plan. HEALTHEXTRAS will be responsible for obtaining the toll-free number and ensuring that it is functioning properly. AMEX shall have the right to approve telecommunications requirements to maximize best efforts and professionalism based on AMEX's experience.

(b) HEALTHEXTRAS agrees that telephone calls to the American Express toll-free number shall be answered "American Express Accidental Disability Plan".

(c) The center shall receive and promptly record all enrollment records, shall set up and maintain each Enrollee's name, address, enrollment number and telephone number on its membership database and shall process and fulfill each enrollment with a fulfillment kit. The center will process customer enrollments, inquires, claims and cancellations.

(d) In the event that an American Express Enrollee attempts to cancel an enrollment, HEALTHEXTRAS will make a good faith effort to "save" the enrollment and persuade the Enrollee not to cancel.

(e) The phone center will also answer Enrollees' questions about the Accidental Disability Plan.

(f) Additionally, the center will distribute fulfillment kits to Enrollees upon enrollment. Fulfillment kits must be distributed to all new Enrollees via First Class U.S. mail approximately forty-eight hours after adding each application to the database.

(g) AMEX may, at its discretion, determine that it is necessary to send Enrollees occasional loyalty efforts and reminders for inventory updates.

(h) HEALTHEXTRAS will forward enrollments, including enrollment effective date, the names of all enrollees, type of plan selected (individual, couple, family), limits of insurance selected, address, account number, amount billed to the Enrollee's Card account, marketing channel and cell code, to AMEX.

Key Process Measure	Accuracy Standard	Timeliness Standard	Description
Telephone Service			
1. Customer Service Inbound/Outbound Calls -includes enrollment, inquiries, customer service, benefits questions 24 hours/day, 7 days/week	Goal – 100% accurate Minimum acceptable – 98%	Call Timeliness Standards Speed of answer 80% answered 0-20 seconds 95% answered 60 seconds Abandoned calls: ≤ 3% abandoned Blocked calls: 0% blocked calls Methodology: Call Reports	Accuracy: Calls handled accurately. Timeliness: Seconds elapsed before a call is answered. Abandoned: Calls that hang up before being answered. Blocked: Calls blocked at the network level
Enrollment			
1. Fulfillment of membership request forms or telemarketing requests.	Goal – 100% accurate Minimum acceptable – 100% Methodology: Sampling	Phone Request: 80% mailed ≤ 2 business days 100% mailed ≤ 5 business days Methodology: Tracking logs	Accuracy: Kits contain accurate materials and are addressed properly. Timeliness: Days to mail kits from date HEALTHEXTRAS receives phone/mail request.
2. Fulfillment of additional requests for identification cards or materials	Goal 100% accurate Minimum acceptable – 100% Methodology: Sampling	Phone Request 95% mailed ≤ 2 business days 100% mailed ≤ 5 business days Mail Request: 80% mailed ≤ 2 business days 100% mailed ≤ 5 business days Methodology: Tracking logs	Accuracy: Kits contain accurate materials and are addressed properly, and correct enrollment numbers are assigned. Timeliness: Days to mail materials from date HEALTHEXTRAS receives phone/mail request.
3. Process cancellations	Goal – 100% accurate Minimum acceptable – 98% Methodology: Sampling	100% of correspondence acknowledged/resolved ≤ 5 business days	Accuracy: Accurate responses to CM inquiries. Timeliness: Number of days from receipt of correspondence until acknowledgment and/or reply is sent.

Key Process Measure	Accuracy Standard	Timeliness Standard	Description
AMEX Customer Complaints			
1. Investigate and answer Enrollee complaints	Goal - 100% Minimum acceptable – 98% Methodology: White mail tracking/phone logs	98% acknowledgment of complaint mailed ≤ 2 business days of initial receipt 100% responses mailed ≤ 10 business days with 2% variance Amex notified by fax <24hours of complaints – 98% 100% notified by fax<48 hours	Accuracy: Concern addressed and responded to correctly. Timeliness: Time elapsed from receipt of complaint until response is mailed.
2. Customer Inquiries	Goal - 100% Minimum acceptable – 98% Methodology: Phone and Mail Reports	100% mailed or acknowledged ≤ 2 business days	Accuracy: Inquiry addressed and responded to correctly. Timeliness: Time elapsed from receipt of inquiry until response is mailed.
Delivery & Promise			
1. Insurance claims processing	Goal - 100% Minimum acceptable – 98% Methodology: Claims reporting	100% acknowledgment of claims with immediate response (process/decline) to the Enrollee. 100% responses mailed ≤ 2 business days with 2% variance (unless indicated below.)	Accuracy: Claim addressed and responded to correctly and immediately. Timeliness: Time elapsed from receipt of claim until response is mailed.
2. Travel assistance services processing	Goal - 100% Minimum acceptable – 98% Methodology: Reports	100% acknowledged and processed same business day (process/decline) from Enrollee's request.	Accuracy: Request addressed and responded to correctly. Timeliness: Time elapsed from receipt of inquiry until response is recorded as closed in the database.

EXHIBIT E

AMEX Data Access Document

Information Security Requirements

The following are provided as minimum requirements or guidelines only. In all instances, the recommendations resulting from all site audits, as indicated in writing to HEALTHEXTRAS, will govern.

GENERAL

Each HEALTHEXTRAS employee, subcontractor, agent or representative shall sign a Confidentiality Agreement or Non-Disclosure Agreement, as applicable, and abide by all terms contained therein.

HEALTHEXTRAS shall allow site audit visit by AMEX assigned staff during all periods of the relationship, including unscheduled visits and reviews with 24 hours notice. AMEX reserves the express right to make unscheduled visits to any and all HEALTHEXTRAS sites when there is a suspicion of a security breach. HEALTHEXTRAS agrees to comply with any recommendations from said audit and reviews.

HEALTHEXTRAS shall ensure all regulations and laws are complied with including:

- Conflicts of Interest
- Confidential Information and Trade Secrets
- Insider Trading
- Copyrights, Trademarks, and Intellectual Property
- Money Laundering
- Political Activities
- Federal Banking Regulations

HEALTHEXTRAS shall maintain an adequate level of physical security controls over the HEALTHEXTRAS Accidental Disability Plan Location including, but not limited to: appropriate alarm systems, access controls, fire suppression, video surveillance, staff (describe allowances for carrying out data) egress searches.

HEALTHEXTRAS shall maintain an adequate level of data security controls including, but not limited to: proper safeguarding of AMEX data, logical access controls (e.g. password protection of AMEX applications, data files, libraries), computer security software, a secure tape library. The

controls maintained by HEALTHEXTRAS shall meet the minimum AMEX Information Security Standards (standards attached).

HEALTHEXTRAS shall maintain an adequately secured computer room facility, with access restricted to only approved HEALTHEXTRAS staff.

HEALTHEXTRAS shall provide to AMEX Information Security management copies of all internal security policies and standards for review prior to the program commencement. This shall include escalation procedures for non-compliance with standards.

HEALTHEXTRAS shall provide to AMEX Information Security management a copy of the most recent third party data processing audit or review, conducted by HEALTHEXTRAS external auditors. HEALTHEXTRAS shall provide to AMEX Information Security management copies of any related data processing audits from their internal audit team.

HEALTHEXTRAS agrees to abide by the Privacy Principles as adopted by AMEX for itself from time to time. Those requirements are currently as follows:

1. Collect only customer information that is needed, and tell customers how it will be used.

   Limit the collection of information about customers to what is needed to be known to administer their accounts, to provide customer services, to offer new products and services, and to fulfill any legal and regulatory requirements. Tell customers about the general uses of the information collected about them, and will provide additional explanation if customers request it.

2. Give customers choices about how their data will be used.

   On a regular basis, give customers the option to decide whether or not they wish to have their names removed from lists used for mail, telephone and online marketing. These "opt-out" choices include product and service offers from AMEX and those made in conjunction with AMEX or HEALTHEXTRAS business partners.

3. Ensure information quality.

   Use advanced technology and well-defined employee practices to help ensure that customer data are processed promptly, accurately and completely. Require high standards of quality from the consumer reporting agencies and others that provide information about prospective customers.

4. Use information security safeguards.

   Access to customer data is limited to those who specifically need it to conduct their business responsibilities. Use security techniques designed to protect customer data -- especially when certain data are used by employees and business partners to fulfill customer services.

5. Limit the release of customer information.